

**DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington**

To: Physical Therapists
Managed Care Plans

Memorandum No: 03-79 MAA
Issued: September 29, 2003

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

For Information Call:
1-800-562-6188

Subject: Physical Therapy: HIPAA Changes

<p>Effective for dates of service on and after October 1, 2003, the Medical Assistance Administration (MAA) will discontinue state-unique procedure code 0002M.</p>
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Coding Changes

The Health Insurance Portability and Accountability Act (HIPAA) requires all healthcare payers to process and pay electronic claims using a standardized set of procedure codes. In order to comply with HIPAA requirements, MAA is discontinuing all state-unique procedure codes and will require the use of applicable Current Procedural Terminology (CPT)TM and Healthcare Common Procedure Coding System (HCPCS) procedure codes.

Effective for dates of service on and after October 1, 2003, providers may no longer bill for splints using state-unique procedure code 0002M. Attached is updated replacement page 15/16 for MAA's Physical Therapy Billing Instructions, dated May 2000, reflecting this change.

Physical therapists who wish to dispense splints from their office must apply for a Prosthetics and Orthotics (P&O) provider number. You may apply for a P&O provider number by going to MAA's website at the following link: <http://maa.dshs.wa.gov/ProvRel/Index.html> or by contacting Provider Enrollment toll-free at (866) 545-0544.

Continued on next page...

Hard Copy Billing Using Expedited Prior Authorization (EPA) Number(s)

With HIPAA implementation, multiple authorization (prior/expedited) numbers can be billed on a claim. If you are billing using a paper HCFA-1500 claim form for supplies or equipment using multiple EPA numbers, you must list the 9-digit EPA numbers in field 19 of the claim form exactly as follows (*not all required fields are represented in the example*):

19. Line 1: 870000725/ Line 2: 870000726
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If you are only billing one EPA number on a paper HCFA-1500 claim form, please continue to list the 9-digit EPA number in field 23 of the claim form.

Attached are updated replacement pages 12a-12b, 25-28, and 33-36 for MAA's Physical Therapy Billing Instructions, dated May 2000, that reflect HIPAA changes.

To obtain this document electronically, go to MAA's website at <http://maa.dshs.wa.gov> (click on the Provider Publications/Fee Schedules link).

Expedited Prior Authorization (EPA)

The EPA process is designed to eliminate the need for written authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an “EPA” number when appropriate.

To bill MAA for diagnoses, procedures and services that meet the EPA criteria on the following pages, the provider must **create a 9-digit EPA number**. The first six digits of the EPA number must be **870000**. The last 3 digits must be the code number of the diagnostic condition, procedure, or service that meets the EPA criteria. Enter the EPA number on the billing form in the authorization number field, or in the *Authorization* or *Comments* field when billing electronically. With HIPAA implementation, multiple authorization (prior/expedited) numbers can be billed on a claim. If you are billing multiple EPA numbers, you must list the 9-digit EPA numbers in field 19 of the claim form exactly as follows (*not all required fields are represented in the example*):

19. Line 1: 870000725/ Line 2: 870000726
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If you are only billing one EPA or PA number on a paper HCFA-1500 claim form, please continue to list the 9-digit EPA number in field 23 of the claim form.

Example: The 9-digit authorization number for additional physical therapy units for a client who has used 48 PT units this calendar year and subsequently has had knee surgery, would be **870000640** (**870000** = first six digits of all expedited prior authorization numbers, **640** = last three digits of an EPA number indicating the service and which criteria the case meets).

Expedited Prior Authorization Guidelines

A. Diagnoses

Only diagnostic information obtained from the hospital or outpatient chart may be used to meet conditions for EPA. Claims submitted without the appropriate diagnosis, procedure code or service as indicated by the last three digits of the EPA number will be denied.

B. Documentation

The billing provider must have documentation of how expedited criteria was met, and have this information in the client’s file available to MAA on request.

**Washington State
Expedited Prior Authorization Criteria Coding List
For Physical Therapy(PT) LEs**

PHYSICAL THERAPY

CPT: 97010-97150, 97520-97537, 97750

Code	Criteria
640	<p><u>An additional 48 Physical Therapy program units</u> when the client has already used the allowed program units for the current year and has <u>one</u> of the following surgeries or injuries:</p> <ol style="list-style-type: none"> 1. Lower Extremity Joint Surgery 2. CVA not requiring acute inpatient rehabilitation 3. Spine surgery
641	<p><u>An additional 96 Physical Therapy program units</u> when the client has already used the allowed program units for the current year and has recently completed an acute inpatient rehabilitation stay.</p>

Are school medical services covered?

MAA covers physical therapy services provided in a school setting for school-contracted services that are noted in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Refer to MAA's School Medical Services Billing Instructions. (See *Important Contacts*.)

What is not covered? [WAC 388-545-500(12)(13)]

- MAA does not cover physical therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.
- MAA does not cover physical therapy services performed by a physical therapist in an outpatient hospital setting when the physical therapist is not employed by the hospital. Reimbursement for services must be arranged through the hospital.

(CPT procedure codes and descriptions are copyright 2001 American Medical Association.)

Physical Therapy Program

Procedure Code	Brief Description	July 1, 2003 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
97504	Orthotic training	\$17.29	\$17.29
97520	Prosthetic training	16.84	16.84
97530	Therapeutic activities	17.29	17.29
97535	Self care mngmt training	18.65	18.65
97537	Community/work reintegration	16.61	16.61
97542	Wheelchair mngmt training	Not Covered	
97545	Work hardening	Not Covered	
97546	Work hardening add-on	Not Covered	
97601	Wound care selective	24.12	24.12
97602	Wound care non-selective	19.11	10.01
Tests and Measurements			
97001	Pt evaluation	44.82	38.45
97002	Pt re-evaluation	24.12	19.34
97703	Prosthetic checkout	13.65	13.65
97005	Athletic evaluation	Not Covered	
97006	Athletic re-evaluation	Not Covered	
97750	Physical performance test	17.52	17.52
Other Procedures			
0002M	<i>Discontinued with dates of service on and after October 1, 2003.</i>		
97532	Cognitive skills development	Not Covered	
97533	Sensory integration	Not Covered	
97799	Unlisted physical medicine rehabilitation service or procedure	By Report	

(CPT codes and descriptions are copyright 2002 American Medical Association.)

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.
- The provider must submit claims as described in MAA's billing instructions.
- MAA requires providers to obtain an ICN for an initial claim within 365 days from any of the following:
 - ✓ The date the provider furnishes the service to the eligible client;
 - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
 - ✓ The date a court orders MAA to cover the services; or
 - ✓ The date DSHS certifies a client eligible under delayed¹ certification criteria.
- MAA may grant exceptions to the 365 day time limit for initial claims when billing delays are caused by either of the following:
 - ✓ DSHS certification of a client for a retroactive² period; or
 - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.
- MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

¹ **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider MUST refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

² **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider MAY refund payment made by the client and then bill MAA for the service.

- 11b. **Employer's Name or School Name:** Primary insurance. When applicable, enter the insured's employer's name or school name.
- 11c. **Insurance Plan Name or Program Name:** Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*
- 11d. **Is There Another Health Benefit Plan?** Required if the client has secondary insurance. Indicate yes or no. If yes, you should have completed *fields 9a.-d.* If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check yes. **If 11d. is left blank, the claim may be processed and denied in error.**
17. **Name of Referring Physician or Other Source:** When applicable, enter the referring physician or Primary Care Case Manager name. This field *must* be completed for consultations, or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source).

- 17a. **LD. Number of Referring Physician:** When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

The referring provider's Medical Assistance provider number or name and the statement "EPSDT referral" must be entered in the appropriate field.

19. **Reserved For Local Use:** When applicable, enter indicator B to indicate *Baby on Parent's PIC.* Enter "T" for school contracted services that are noted in the client's IEP or EFSP. Direct entry and electronic billers must use their appropriate field. **If you have more than one EPA number to bill, place both numbers here.**
21. **Diagnosis or Nature of Illness or Injury:** When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.
22. **Medicaid Resubmission:** When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the claim number listed on the Remittance and Status Report.)

23. **Prior Authorization Number for Limitation Extensions:** When applicable. If the service or equipment you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.
24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.**
- 24A. **Date(s) of Service:** Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2003 = 100403). **Do not use slashes, dashes, or hyphens to separate month, day, or year (MMDDYY).**
- 24B. **Place of Service:** Required. These are the only appropriate code(s) for Washington State Medicaid:
- | <u>Code Number</u> | <u>To Be Used For</u> |
|---------------------------|------------------------------|
| 11 | Office |
| 12 | Client's residence |
| 99 | Other |
- 24C. **Type of Service:** No longer required.
- 24D. **Procedures, Services or Supplies CPT/HCPCS:** Required. Enter the appropriate Current Procedural Terminology (CPT) or HCFA Common Procedure Coding System (HCPCS) procedure code for the services being billed.

- 24E. **Diagnosis Code:** Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM.
- 24F. **\$ Charges:** Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. **Do not include** dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.
- 24G. **Days or Units:** Required. Enter the total number of program units for each line. These figures must be whole units.
25. **Federal Tax I.D. Number:** Leave this field blank.
26. **Your Patient's Account No.:** Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.
28. **Total Charge:** Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid:** If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not put Medicare payment here or use dollar signs or decimals in this field.
30. **Balance Due:** Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.
33. **Physician's, Supplier's Billing Name, Address, Zip Code and Telephone Number:** Required. Put the *Name, Address, and Telephone Number* on all claim forms.
- Group:** Required. Please enter your seven-digit provider number assigned to you by MAA.

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PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY		7. INSURED'S ADDRESS (No., Street)	
STATE		CITY	
ZIP CODE		STATE	
TELEPHONE (Include Area Code) ()		ZIP CODE	
TELEPHONE (INCLUDE AREA CODE) ()		11. INSURED'S POLICY GROUP OR FECA NUMBER	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____			
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____			

14. DATE OF CURRENT: MM DD YY		ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
19. RESERVED FOR LOCAL USE		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____		23. PRIOR AUTHORIZATION NUMBER	

A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE	
From	To					CPT/HCPCS	MODIFIER														
MM	DD	YY	MM	DD	YY																
1																					
2																					
3																					
4																					
5																					
6																					

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. \$ TOTAL CHARGE		29. \$ AMOUNT PAID		30. \$ BALANCE DUE	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____			

- | | |
|---|--|
| <p>11a. <u>Insured's Date of Birth:</u> Primary insurance. When applicable, enter the insured's birthdate, if different from <i>field 3</i>.</p> <p>11b. <u>Employer's Name or School Name:</u> Primary insurance. When applicable, enter the insured's employer's name or school name.</p> <p>11c. <u>Insurance Plan Name or Program Name:</u> Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. (<i>Note: This may or may not be associated with a group plan.</i>)</p> <p>11d. <u>Is There Another Health Benefit Plan?</u> Required if the client has secondary insurance. Indicate <i>yes</i> or <i>no</i>. If yes, you should have completed <i>fields 9a.-d</i>. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check <i>yes</i>. If 11d. is left blank, the claim may be processed and denied in error.</p> <p>19. <u>Reserved For Local Use:</u> Required. When Medicare allows services, enter <i>XO</i> to indicate this is a crossover claim.</p> | <p>22. <u>Medicaid Resubmission:</u> When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the <i>claim number</i> listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).</p> <p>24. <u>Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.</u></p> <p>24A. <u>Date(s) of Service:</u> Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2003 = 100403). Do not use slashes, dashes, or hyphens to separate month, day or year (MMDDYY).</p> <p>24B. <u>Place of Service:</u> Required. Enter a 11.</p> <p>24C. <u>Type of Service:</u> No longer required.</p> <p>24D. <u>Procedures, Services or Supplies CPT/HCPCS:</u> Required.
 <u>Coinurance and Deductible:</u>
 Enter the total combined and deductible for each service in the space to the right of the modifier on each detail line.</p> <p>24E. <u>Diagnosis Code:</u> Enter the ICD-9-CM diagnosis code related to the procedure or service being billed.</p> |
|---|--|

- 24F. **\$ Charges:** Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.
- 24G. **Days or Units:** Required. Enter the total number of program units for each line. These figures must be whole units.
- 24K. **Reserved for Local Use:** Required. Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).
26. **Your Patient's Account No.:** Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.
27. **Accept Assignment:** Required. Check **yes**.
28. **Total Charge:** Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid:** Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**
30. **Balance Due:** Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**
32. **Name and Address of Facility Where Services Are Rendered:** Required. Enter Medicare Statement Date *and* any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**
33. **Physician's, Supplier's Billing Name, Address, Zip Code and Telephone Number:** Required. Put the *Name, Address, and Telephone Number* on all claim forms.
- Group:** Required. Please enter your seven-digit provider number assigned to you by MAA.

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HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
STATE		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
ZIP CODE		11. INSURED'S POLICY GROUP OR FECA NUMBER	
TELEPHONE (Include Area Code) ()		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		b. EMPLOYER'S NAME OR SCHOOL NAME	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		c. INSURANCE PLAN NAME OR PROGRAM NAME	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
c. EMPLOYER'S NAME OR SCHOOL NAME		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.			
SIGNED _____ DATE _____			
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
1. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
2. _____		23. PRIOR AUTHORIZATION NUMBER	
3. _____			
4. _____			
24. A DATE(S) OF SERVICE. From MM DD YY To MM DD YY		B Place of Service	
C Type of Service		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
E DIAGNOSIS CODE		F \$ CHARGES	
G DAYS OR UNITS		H EPSDT Family Plan	
I EMG		J COB	
K RESERVED FOR LOCAL USE			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. \$ TOTAL CHARGE	
29. \$ AMOUNT PAID		30. \$ BALANCE DUE	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	
SIGNED _____ DATE _____		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	
		PIN# _____ GRP# _____	

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HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
STATE		CITY	
ZIP CODE		STATE	
TELEPHONE (Include Area Code) ()		ZIP CODE	
TELEPHONE (INCLUDE AREA CODE) ()		11. INSURED'S POLICY GROUP OR FECA NUMBER	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____			
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____			
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
1. _____ 3. _____ 2. _____ 4. _____		23. PRIOR AUTHORIZATION NUMBER	
24. A DATE(S) OF SERVICE. From To MM DD YY MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. \$ TOTAL CHARGE	
29. \$ AMOUNT PAID		30. \$ BALANCE DUE	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____			